

(b) As part of the quality performance score, the quality measure regarding EHR adoption will be measured based on a sliding scale.

(c) Performance on this measure will be weighted twice that of any other measure for scoring purposes and for determining compliance with quality performance requirements for domains.

Subpart G—Shared Savings and Losses

§ 425.600 Selection of risk model.

(a) For its initial agreement period, an ACO may elect to operate under one of the following tracks:

(1) *Track 1.* Under Track 1, the ACO operates under the one-sided model (as described under § 425.604 of this part) for the agreement period.

(2) *Track 2.* Under Track 2, the ACO operates under the two-sided model (as described under § 425.606), sharing both savings and losses with the Medicare program for the agreement period.

(b) For subsequent agreement periods, an ACO may not operate under the one-sided model.

(c) An ACO experiencing a net loss during the initial agreement period may reapply to participate under the conditions in § 425.202(a), except the ACO must also identify in its application the cause(s) for the net loss and specify what safeguards are in place to enable the ACO to potentially achieve savings in its next agreement period.

§ 425.602 Establishing the benchmark.

(a) *Computing per capita Medicare Part A and Part B benchmark expenditures.* In computing an ACO's fixed historical benchmark that is adjusted for historical growth and beneficiary characteristics, including health status, CMS determines the per capita Parts A and B fee-for-service expenditures for beneficiaries that would have been assigned to the ACO in any of the 3 most recent years prior to the agreement period using the ACO participants' TINs identified at the start of the agreement period. CMS does all of the following:

(1) Calculates the payment amounts included in Parts A and B fee-for-service claims using a 3-month claims run out with a completion factor.

(i) This calculation excludes indirect medical education (IME) and disproportionate share hospital (DSH) payments.

(ii) This calculation considers individually beneficiary identifiable payments made under a demonstration, pilot or time limited program.

(2) Makes separate expenditure calculations for each of the following populations of beneficiaries: ESRD, disabled, aged/dual eligible Medicare and Medicaid beneficiaries and aged/non-dual eligible Medicare and Medicaid beneficiaries.

(3) Adjusts expenditures for changes in severity and case mix using prospective HCC risk scores.

(4) Truncates an assigned beneficiary's total annual Parts A and B fee-for-service per capita expenditures at the 99th percentile of national Medicare fee-for-service expenditures as determined for each benchmark year in order to minimize variation from catastrophically large claims.

(5)(i) Using CMS Office of the Actuary national Medicare expenditure data for each of the years making up the historical benchmark, determines national growth rates and trends expenditures for each benchmark year (BY1 and BY2) to the third benchmark year (BY3) dollars.

(ii) To trend forward the benchmark, CMS makes separate calculations for expenditure categories for each of the following populations of beneficiaries: ESRD, disabled, aged/dual eligible Medicare and Medicaid beneficiaries and aged/non-dual eligible Medicare and Medicaid beneficiaries.

(6) Restates BY1 and BY2 trended and risk adjusted expenditures in BY3 proportions of ESRD, disabled, aged/dual eligible Medicare and Medicaid beneficiaries and aged/non-dual eligible Medicare and Medicaid beneficiaries.

(7) Weights each year of the benchmark using the following percentages:

(i) BY3 at 60 percent.

(ii) BY2 at 30 percent.

(iii) BY1 at 10 percent.

(8) The ACO's benchmark may be adjusted for the addition and removal of ACO participants or ACO providers/suppliers during the term of the agreement period.

(b) *Updating the benchmark.* CMS updates the historical benchmark annually for each year of the agreement period based on the flat dollar equivalent of the projected absolute amount of growth in national per capita expenditures for Parts A and B services under the original Medicare fee-for-service program.

(1) CMS updates this fixed benchmark by the projected absolute amount of growth in national per capita expenditures for Parts A and B services under the original Medicare fee-for-service program using data from CMS' Office of the Actuary.

(2) To update the benchmark, CMS makes expenditure calculations for separate categories for each of the following populations of beneficiaries:

- (i) ESRD.
- (ii) Disabled.
- (iii) Aged/dual eligible Medicare and Medicaid beneficiaries.
- (iv) Aged/non-dual eligible Medicare and Medicaid beneficiaries.

(c) *Resetting the benchmark.* An ACO's benchmark will be reset at the start of each agreement period.

§ 425.604 Calculation of savings under the one-sided model.

(a) *Savings determination.* For each performance year, CMS determines whether the estimated average per capita Medicare expenditures under the ACO for Medicare fee-for-service beneficiaries for Parts A and B services are below the applicable updated benchmark determined under § 425.602.

(1) *Newly assigned beneficiaries.* CMS uses an ACO's HCC prospective risk score to adjust for changes in severity and case mix in this population.

(2) *Continuously assigned beneficiaries.*

(i) CMS uses demographic factors to adjust for changes in the continuously assigned population.

(ii) If the prospective HCC risk score is lower in the performance year for this population, CMS will adjust for changes in severity and case mix in this population using this lower prospective HCC risk score.

(3) Assigned beneficiary changes in demographics and health status are

used to adjust benchmark expenditures as described in § 425.602(a). In adjusting for health status and demographic changes CMS makes adjustments for separate categories for each of the following populations of beneficiaries:

- (i) ESRD.
- (ii) Disabled.
- (iii) Aged/dual eligible Medicare and Medicaid beneficiaries.
- (iv) Aged/non-dual eligible Medicare and Medicaid beneficiaries.

(4) To minimize variation from catastrophically large claims, CMS truncates an assigned beneficiary's total annual Parts A and B fee-for-service per capita expenditures at the 99th percentile of national Medicare fee-for-service expenditures as determined for each performance year.

(5) CMS uses a 3 month claims run out with a completion factor to calculate an ACO's per capita expenditures for each performance year.

(6) Calculations of the ACO's expenditures will include the payment amounts included in Part A and B fee-for-service claims.

(i) These calculations will exclude indirect medical education (IME) and disproportionate share hospital (DSH) payments.

(ii) These calculations will take into consideration individually beneficiary identifiable payments made under a demonstration, pilot or time limited program.

(7) In order to qualify for a shared savings payment, the ACO's average per capita Medicare expenditures for the performance year must be below the applicable updated benchmark by at least the minimum savings rate established for the ACO under paragraph (b) of this section.

(b) *Minimum savings rate (MSR).* CMS uses a sliding scale, based on the number of beneficiaries assigned to the ACO under subpart E of this part, to establish the MSR for an ACO participating under the one-sided model. The MSR under the one-sided model for an ACO based on the number of assigned beneficiaries is as follows: